FORM APPROVED

CENTERS FOR MEDICARE & MEDICA	ID SEKVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 144040	A. BUILDING	(X3) DATE SURVEY COMPLETED 05/17/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, ST	ATE, ZIP	
CHICAGO BEHAVIORAL HOSPITAL	555 WILSON LANE, DES PLAINES, IL, 60016		
For information on the provider's plan	to correct this deficiency, ple	ase contact the provider or th	e state survey agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		

TITLE

(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF **DEFICIENCIES** AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER**

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

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05/17/2019

NAME OF PROVIDER OR SUPPLIER

CHICAGO BEHAVIORAL HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP

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40079

An investigation was conducted on 5/17/19 for Complaint #IL00112091/192503. The Hospital was not in compliance with the Condition of Participation, 42 CFR 482.13 Patient Rights, as evidenced by:

An Immediate Jeopardy (IJ) was identified on 5/17/19, due to the Hospital's failure to ensure that psychiatric patients that are placed in the seclusion room and/or quiet room on the Behavioral Health Units (ITU - Intensive Treatment Unit - 1 West, TCU - Transitional Care Unit - 2 West and 2 South) were protected from risk of causing serious self-harm/injury.

The IJ was identified and announced on 5/17/19 at 1:24 PM, during a meeting with the Director of Nursing, Assistant Director, Director of Performance Improvement/Risk Management, and the Chief Executive Officer of the Hospital. The IJ was not removed by the survey exit date of 5/17/19.

A0115

Patient Rights

482.13

Corrected On: 06/07/2019

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Based on document review, observation, and interview, it was determined that the Hospital failed to ensure that patients that were placed in the seclusion room and/or quiet room were protected from causing self-harm/injury. This potentially places all future psychiatric patients with symptoms of self-harm/injury at risk for serious harm. As a result, the Condition of Participation, 42 CFR 482.13 Patient Rights, was not in compliance.

Findings include:

1. The Hospital failed to ensure that a patient placed in the seclusion room and/or quiet room was protected from causing self-harm.

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The IJ was identified and announced on 5/17/19 at 1:24 PM, during a meeting with the Director of Nursing, Assistant Director, Director of Performance Improvement and Risk Management, and the Chief Executive Officer of the Hospital. The IJ was not removed by the survey exit date of 5/17/19.

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A0144

Patient Rights: Care In Safe Setting

482.13(c)(2)

Corrected On: 06/07/2019

40079

Based on document review, observation, and interview, it was determined that for 3 of 7 Behavioral Health Units (ITU-1 West, TCU- 2 West and 2 South), the Hospital failed to ensure that psychiatric patients that are placed in the seclusion room and/or quiet room were protected from risk of causing serious self-harm/injury. Subsequently, a patient's (Pt. #1's) injury followed.

Findings include:

- 1. The Hospital's policy titled, "Restraint and/or Seclusion (effective 11/14), was reviewed and included, "...Definitions: 3. Seclusion is the involuntary confinement of a patient alone in a room or area...Seclusion may be used for management of violent or self-destructive behavior...Policy...E. The use of restraint/seclusion is justified to prevent the patient from causing physical harm to himself or others...N. The patient in restraint/seclusion shall be monitored by continuous in-person observation by a staff member who is trained and competent in the care of a patient in restraint/seclusion..."
- 2. The clinical record for Pt #1 was reviewed on 5/14/19. Pt # 1 was a 22 year old male admitted to the Hospital on 5/7/19 at 6:45 AM through 5/7/19 at

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8:30 PM, with the diagnoses of brief psychotic disorder and suicidal ideation.

- The Initial Nursing Assessment dated 5/7/19 at 10:00 AM, was reviewed and included, "Body Check/Safety Search Performed By: two Registered Nurses; No bruises, or lacerations were identified..."
- -A physician's order dated 5/7/19 at 8:35 AM, included, "Type of Restraint: Seclusion Start time 8:35 AM Stop time 12:10 PM; Reason for Restraint/Seclusion Physical threatening behavior, suggestive of imminent harm to self or others."
- -The Restraint/Seclusion Monitoring sheet dated 5/7/19 from 8:35 AM to 12:10 PM was reviewed and included, "Restraint Type S (Seclusion), Behavior P1 (Physical Aggression), V1 (Yelling), A2 (Agitation-expression of verbal distress), Signs of Injury Y (yes) at 8:50 AM to 12:10 PM, Release N (No) from 8:35 AM to 12:05 AM ..."
- A Clinical Note entered by a Registered Nurse (RN-E #8) dated 5/7/19 at 1:00 PM, was reviewed and included, "Staff reported to NOD (nurse on duty) that the patient (Pt #1) lost his balance and was moving/walking backwards and hit his back against the door of the seclusion room and patient (Pt #1) ended up on the floor. Patient (Pt #1) stood up again and started walking, bumping on the wall and noted with facial bumps, swelling/redness on both eyebrows and upper lip ...Doctor (MD #2) made aware

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- -The Psychiatric evaluation dated 5/7/19 at 11:00 AM, was reviewed and included, "Patient is a 22 year old male with history of substance abuse ...admitted to the Hospital after he presented to ED (Emergency Department) with si/sx (suicidal ideation symptoms) consistent with acute psychosis ...Patient is in need of immediate hospitalization due to risk of harm to self and others ...Mental Status Examination General appearance, Attitude and Behavior: a. Clothes/Hygiene: naked, bumping into walls in his room being redirected, eyes half closed picking at the air ..."
- -The High Risk Patient Precautions Records sheet dated 5/7/19 from 12:20 PM to 8:50 PM, was reviewed and indicated that Pt #1 was in the quiet room with a sitter.
- A Clinical Note entered by E #8 dated 5/7/19 at 2:00 PM, was reviewed and included, "Patient (Pt #1) is still restless and walking into the wall, needs redirection. Pt #1 is not cooperative with nursing care...Resistive...Pt #1 is still bumping his shins on his bed."
- 3. Video recording of the ITU Seclusion Room on 5/7/19 between 8:30:35 AM to 12:07:40 PM was reviewed on 5/15/19 at approximately 11:00 AM, with the Director of Performance Improvement (E #12).
- -At 8:30:35 AM, Pt #1 was escorted by staff into the seclusion room and after the door was closed, Pt #1 picked at the walls and the floor, as if trying to grab small objects. The outside view of the seclusion room showed staff observing Pt #1 through

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the window on the door during the entire time Pt #1 was in the seclusion room.

-At 8:41:10 AM, Pt #1 is seen getting down on his knees and begins to take of his clothes. Pt #1 stands up and is pacing back and forth, walks to the wall, faces the wall and moves his body from side to side repeatedly. From this angle Pt #1's body, from the shoulders above, was out of view of the camera.

-At 10:11:30 AM, Staff including E #4 (Director of Nursing), E #8 (Registered Nurse), E #13 (Mental Health Technician), and E #15 (Mental Health Technician) entered the seclusion room to administer medication to Pt #1. Pt #1 continued with same behavior of pacing, at times losing his balance and walking into the wall, and rubbing his body (face forward) against the wall until he was taken out of the seclusion room at 12:07:20 PM.

The video surveillance for the quiet room for 5/7/19 between 12:07:40 PM to 4:01:30 PM, was reviewed.

-At 12:07:40 PM, Staff escorted Pt #1 to the quiet room. Staff was observed monitoring the patient while in the quiet room.

-At 12:13:30 PM to 4:01:30 PM, Staff entered the quiet room several times, during this time Pt #1 was observed pacing, going towards the wall and window. Pt #1 was observed walking towards foot of the bed several times, and at one point, Pt #1 was observed flopped forward onto the bed. The MHT (Mental Health Technician) assigned to observe Pt #1was trying to steer and direct the patient away from the wall and

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the bed.

- -At 4:01:30 PM, Staff placed Pt #1 in mechanical restraints (soft wrist restraints on both arms and legs) and brought a vital signs machine into the quiet room.
- 4. On 5/14/19 between 10:30 AM to 11:10 AM an observational tour of 2 West and 2 South Transitional Care Unit was conducted. There were six (6) patients on suicidal ideation precautions. No patients on restraints or seclusion or on one-to-one monitoring (1:1 constant line of vision observation by a single observer who is able to provide immediate intervention of any self-injurious behaviors). On 2 South, there were six (9) patients on suicidal ideation precautions; however, there were no patients on restraint or seclusion or on 1:1 constant line of vision observation by a single observer who is able to provide immediate intervention monitoring. The seclusion room was unpadded.
- 5. On 5/14/19 between 2:00 PM to 2:15 PM an observational tour of 1 West Intensive Treatment Unit was conducted. 1 West has a capacity of 10 patients with a census of 9 patients. The unit was staffed by one (1) RN and two (2) MHT 's. There were no patients on restraints or seclusion or 1:1 monitoring. The seclusion room was unpadded.
- 6. On 5/14/19 at approximately 2:10 PM, an interview was conducted with the Director of Nursing (DON E #4). E #4 stated that, if the patient is unable to be re-directed, the patient will then have to be

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placed in restraints. E #4 stated that, after Pt #1 was medicated and did not respond or show improvement, the next step should have been to place Pt. #1 in mechanical restraints or send out for a medical evaluation.

- 7. On 5/16/19 at approximately 10:18 AM, an interview was conducted with an MHT (E #14). E #14 stated, "I work 2nd shift, I was assigned as one-toone with Pt #1, when he was in the quiet room. The door was kept open for direct observation. Pt #1 was talking to himself, walking into the walls, his behavior was not normal. As Pt #1 was walking he was tripping and stumbling with the bed, his balance was not stable. Pt #1 was bruising his face, eyes, and the side of his face and the lips by walking into the wall, not too forcefully but repeatedly. Pt #1 s face kept making contact with the wall, he was not slamming into it but he kept making same constant movements and hitting same spots which caused the bruising. I notified the nurse that the patient kept hurting himself, and was not re-directable. Pt #1 had to be placed in restraints for less than an hour, and after taking Pt #1 off restraints, Pt #1 continued same behavior. Pt #1 continued to try to walk and had poor balance and I had to keep watching him so he would not fall. I had to sit with him until he was transferred. The nurse on duty came in to check on the patient, and checked the vital signs and bruises."
- 8. On 05/17/19 at approximately 12:45 PM, and interview was conducted with the Director of Performance Improvement and Risk Management (E #12). E #12 stated that, when a patient is in the

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seclusion and/or quiet room, they (the staff) are there to protect them (the patients) from getting hurt or hurting others. E #12 stated that Pt #1's situation was very tricky because Pt #1 was not responding to the medication that was given. E #12 stated, "Staff should have done something else to protect Pt #1 after the medication given was not preventing the patient from Pt #1's behavior."

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